

Client Based Venues, Pre and Post Assessments

- ▶ Step 1: Fill out Venue Template Page 1 send to TA for approval
- ▶ Step 2: Go to Venue fill out Pre Assessments on all venue participants
- ▶ Step 3: Fill out Venue Template Page 2
- ▶ Step 4: Send page 1 approved venue along with page 2 to TA for consideration of payment for venue time.
- ▶ Step 5: Send Pre Assessment to TA for review or use Monkey Survey. TA will review Assessments and then send on to Central Office for data entry. Pre Assessment will be entered into Med-It by Central Office within 5-7 days of receiving from TA.
- ▶ Step 6: Community based clients will now show up on your Health Coaching list run by your TA.
- ▶ Step 7: Health Coach you community clients in MedIt
- ▶ Step 8: Fill out and send in Post Assessments to TA when health coaching is done.

Community Venue Pg 1

- ▶ Community Health Hub: acronym of Hub
- ▶ Submitted by: Name of person filling out form
- ▶ Venue Name: Name of Venue Ex: St Francis, NDPP Session Zero
- ▶ Venue Date: Date of Venue
- ▶ Venue Location: Location of venue
- ▶ Venue Type: Put a check mark by or circle type of venue
- ▶ Venue Health Focus: Diabetes, Preventive Screenings, Smoking, Medical Access etc
- ▶ Describe the venue and any partnerships with Venue: write out answer
- ▶ What makes this a good venue...: write out answer
- ▶ Have you participated...: write out answer
- ▶ Send page 1 to TA for venue approval

Community Health Hubs Venue Summary Report Template



Purpose of Template: This template is for identifying, planning and monitoring community reach

- Patient pathway for Navigation and Health Coaching must be submitted. Sample pathway for Navigation on website: Venue-Navigation to Screen Pathway.pdf
- There is a **maximum** of \$4000.00 to be used towards community venues. No pre/post venue time will be reimbursed.
- Venues are payable when they have a minimum of 10% of reach navigated.

All priority populations reached at the venue must have a risk assessment

Venues without 10% of reach navigated will not be payable.

Community Health Hub:		Venue Target Reach:	
Submitted By:		<input type="checkbox"/> Women 18-39 <input type="checkbox"/> Women 40-74	
Venue Name:	Venue Date:	Venue Location:	
Venue Type	Local Health Dept	Venue Health Focus Describe Health Focus	
Community Based	School Site		
Faith Based	Worksite		
Hospital Site			
Describe this venue and any partnerships with venue?			
What makes this a good community venue for reaching priority population with the goal of Navigation and/or Health Coaching?			
Have you participated in this venue in the past and was it successful in reaching clients in need of Navigation and/or Health Coaching?			
Internal Use Only: Pre-Venue			
DHHS Approval			
<input type="checkbox"/> Reasonable expectation of being a successful venue met			
<input type="checkbox"/> Pathway to navigation logical and meets requirements			
<input type="checkbox"/> Pathway to health coaching and HBSS logical and meets requirements			
<input type="checkbox"/> Appropriate Patient Pathway submitted			
DHHS Signature:		Date of Signature: ____/____/____	

Community Venue Pg 2

Venue Information - All of the information on Page 2 is from your Pre Assessments and must be filled out for payment consideration of venue time.

- ▶ Number of Individual Encounters: number of people at the venue who filled out a pre assessment
- ▶ Number of Women Reached in the Priority Age Group: Number of women 40-75 that filled out a Pre Assessment
- ▶ Number of Women Reached in need of Navigation: number of women from the pre assessments that are in need of Breast and/or Cervical navigation.
- ▶ Number of Women Reached in need of Health Coaching: number of women from the pre assessments, age 40-64, that are in need of Health Coaching
- ▶ Number of Non-White: number of non white individuals at the venue that filled out a pre assessment.
- ▶ Number of Hispanic: number of Hispanic individuals at the venue that filled out a pre assessment
- ▶ Number of Uninsured: number of uninsured individuals at the venue that filled out a pre assessment

Venue Time and Staff Name

- ▶ Name of individual that worked the venue with total time worked.
 - ▶ Prep time is not included in time worked at the venue

Venue Information

Number of Individual Encounters: _____

Number of Women Reached in the Priority Age Group: _____

Number of Women Reached in need of Navigation: _____

Number of Women Reached in need of Health Coaching: _____

Number of Non-White:

Number of Hispanic:

Number of Uninsured:

Venue Time and Staff Name:

Name: _____

Total time: _____

Name: _____

Total time: _____

Name: _____

Total time: _____

Pages 1 and 2 must be submitted together for determination of reimbursement for all venues except Monthly HUB venue

COMMUNITY HUB MONTHLY VENUE Page 2 submitted only.

In House Monthly Walk in and Phone Call venue Page 2 filled out and submitted with check box marked and Name of HUB along with Month and Year. Example: LLCHD March 2023

_____ Month _____ Year

Revised: 3-23-2023

Community Monthly Venue Pg 2 Cont

Venue Information - All of the information on Page 2 is from your Pre Assessments and must be filled out for payment consideration of venue time.

For Community Monthly Venues Hubs no longer need to fill out Page 1 of the Venue Template. Page 2 is required for payment consideration of venue time

Community Monthly Venues are for walk in and client calls received by the participating Local Health Hub, where a pre assessment has been filled out for the client.

- ▶ Fill out all information on page 2, as per instructions on previous page, through venue time and staff names
- ▶ Fill out HUB Name
- ▶ Fill out Month and Year of venue
 - ▶ Example: LLCHD April 2023
- ▶ Page 2 in its entirety must then be sent to TA for payment consideration of venue time.

Venue Information

Number of Individual Encounters: _____

Number of Women Reached in the Priority Age Group: _____

Number of Women Reached in need of Navigation: _____

Number of Women Reached in need of Health Coaching: _____

Number of Non-White:

Number of Hispanic:

Number of Uninsured:

Venue Time and Staff Name:

Name: _____

Total time: _____

Name: _____

Total time: _____

Name: _____

Total time: _____

Pages 1 and 2 must be submitted together for determination of reimbursement for all venues except Monthly HUB venue

COMMUNITY HUB MONTHLY VENUE Page 2 submitted only.

In House Monthly Walk in and Phone Call venue Page 2 filled out and submitted with check box marked and Name of HUB along with Month and Year. Example: LLCHD March 2023

_____ HUB Name _____ Month _____ Year

Revised: 3-23-2023

Community Based PRE Assessment

Women aged 40-64

- Date Completed: date of venue when pre assessment was filled out.
- Venue Name: Name of approved venue or Comm Monthly Venue ex: LLCHD Comm Monthly Venue or LLCHD St Francis or LLCHD NDPP West Point Session Zero.
- Community Health Hub: Choose your Hub
- Client ID#: (clients first 3 letters of last name and date of birth mmddyy, example CRA020564)
- Birthdate: Date of birth of client
- All questions on the 2 page Pre Assessment must be answered

Biometrics - All are required for health coaching clients

- Date of Blood Pressure, Height, Weight: date taken
- BP1 and BP2: Both blood pressures are required
- Height: Required
- Weight: Required
- Waist Circumference: Wanted by CDC if can get
- Total Cholesterol: total cholesterol is required on ALL HC clients
- Performed by:
 - Performed by Health Coach if health coach took cholesterol
 - Performed by Healthcare Provider if performed by provider
 - Self Reported
- Date of Total Cholesterol: date taken by HC or provider

COMMUNITY BASED HEALTH COACHING Initial Intake and Pre-Assessment



301 Centennial Mall South - P.O. Box 94817
Lincoln, NE 68509-4817 Fax: 402-471-0913
1-800-532-2227
www.dhhs.ne.gov/womenshealth
Reasonable accommodations made for persons with disabilities. TDD (800) 633-7352
Nebraska DHS provides language assistance at no cost to limited English proficient persons who seek our services.

NOTES:

- Who is this form for? Women age 40-64 who are uninsured, under-insured and/or do not qualify for EWM.
- Please complete assessment form and submit to the Women's and Men's Health Program at the following email: dhhs_ewm@nebraska.gov or complete online by going to: <https://www.surveymonkey.com/r/CRHCPreAssessment>

Please answer each question and PRINT clearly!

Date Completed: ____/____/____ Venue Name: _____

Community Health Hub (CHH):

Central District Health Department - CDHD Elkhorn Logan Valley Public Health Department - ELVPHD
 Lincoln Lancaster County Health Department - LLCHD Panhandle Public Health Department - PPHD
 South Heartland District Health Department - SHDHD Southwest Nebraska Public Health Department - SWNPHD
 Three Rivers Public Health Department - 3RPHD Other _____

Client ID#: _____ (clients first 3 letters of last name and date of birth mmddyy; example CRA020564)

Birthdate: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

BIOMETRICS

Date of Blood Pressure, Height, Weight: ____/____/____

BP 1: ____/____ BP 2: ____/____

Height: _____ Weight: _____

Waist Circumference: _____

Total Cholesterol: _____

Not Applicable Refused
 Performed by Health Coach Self Reported
 Performed by Healthcare Provider

Date of Total Cholesterol: ____/____/____

Community Based POST Assessment

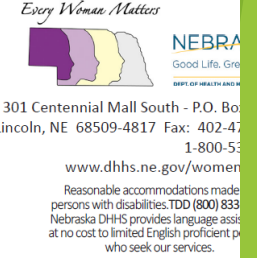
Women aged 40-64

- Date Completed: date post assessment filled out with Client
- Community Health Hub: Choose your Hub
- Client ID#: (clients first 3 letters of last name and date of birth mmddyy, example CRA020564)
- MedIt ID#: Clients MedIt ID# from Health Coaching list
- Birthdate: Date of birth of client
- All questions on the 2 page Post Assessment must be answered

Biometrics -

- Date of Blood Pressure, Height, Weight: date taken
- BP1 and BP2: Both blood pressures are required
- Height: Required
- Weight: Required
- Waist Circumference: Wanted if can get
- Total Cholesterol: Required only if previous Cholesterol was 240 mg/dl and above
- Performed by:
 - Performed by Health Coach if health coach took cholesterol
 - Performed by Healthcare Provider if performed by provider
 - Self Reported
- Date of Total Cholesterol: date taken by HC or provider

COMMUNITY BASED HEALTH COACHING Post-Assessment



NOTES:

- Who is this form for? Women age 40-64 who are uninsured, under-insured and/or do not qualify for EWM.
- Please complete assessment form and submit to the Women's and Men's Health Program at the following email: dhhs.ewm@nebraska.gov or complete online by going to: <https://www.surveymonkey.com/r/CBHCPostAssessment>
- Post Biometrics are REQUIRED. If previous cholesterol was 240 mg/dl and above total cholesterol is also required.

Please answer each question and PRINT clearly!

CLIENT INFORMATION

Date Completed: ____/____/____

Community Health Hub (CHH):

<input type="radio"/> Central District Health Department - CDHD	<input type="radio"/> Elkhorn Logan Valley Public Health Department - ELVPHD
<input type="radio"/> Lincoln Lancaster County Health Department - LLCHD	<input type="radio"/> Panhandle Public Health Department - PPHD
<input type="radio"/> South Heartland District Health Department - SHDHD	<input type="radio"/> Southwest Nebraska Public Health Department - SWNPHD
<input type="radio"/> Three Rivers Public Health Department - 3RPHD	<input type="radio"/> Other _____

Client ID#: _____ MedIt ID#: _____

Birthdate: ____/____/____

BIOMETRICS

Date of Blood Pressure, Height, Weight: ____/____/____

BP 1: ____/____ BP 2: ____/____

Height: _____ Weight: _____

Waist Circumference: _____

Total Cholesterol: _____

<input type="radio"/> Not Applicable	<input type="radio"/> Refused
<input type="radio"/> Performed by Health Coach	<input type="radio"/> Self Reported
<input type="radio"/> Performed by Healthcare Provider	

Date of Total Cholesterol: ____/____/____